STRATEGY RESEARCH PROJECT

THE MEDICAL FOREIGN AREA OFFICER — A FORCE MULTIPLIER IN FUTURE OPERATIONS

BY

COLONEL PRISCILLA H. HAMILTON
United States Army

USAWC CLASS OF 2001
U.S. ARMY WAR COLLEGE, CARLISLE BARRACKS, PA 17013-5050

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Priscilla H. Hamilton, COL, DE
United States Army

Cloyd B. Gatrell, COL, MC
Project Advisor

U.S. Army War College
CARLISLE BARRACKS, PENNSYLVANIA 17013

ABSTRACT

AUTHOR: Priscilla H. Hamilton, COL, DE

TITLE: The Medical Foreign Area Officer – A Force Multiplier in Future Operations

FORMAT: Strategy Research Project

DATE: 10 April 2001 PAGES: 34 CLASSIFICATION: Unclassified

Future operations, especially Operations Other Than War (OOTW), will require close coordination of medical assets in the theater of operation. An in-depth understanding of the culture and medical capabilities of the area of operation will facilitate rapid medical treatment of both military and indigenous populations. This research project will explore the history of medical operations in OOTW, medical demands of future operations, and propose a plan of action for developing medical foreign area officers to support the unified CINCs.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

I wish to thank COL Harrison Hassell of the Center for Health Education and Studies, AMEDD Center and School, and COL (Ret) Gregg Stevens of Booz-Allen-Hamilton for stimulating my thought on this subject and encouraging my participation in the Joint Medical Wargame. I also wish to thank those Army Medical Department personnel who have deployed in support of numerous peacekeeping and humanitarian missions, and willingly shared their experiences with me. Finally, none of my endeavors throughout my career would have been successful without the unfailing support of my husband, Robert A. Gibson, who left this mortal life too soon.

LIST OF ILLUSTRATIONS

THE MEDICAL FOREIGN AREA OFFICER - A FORCE MULTIPLIER IN FUTURE OPERATIONS

The nation's strategy is at a point of transition under a new administration. The national security strategy of Engagement defined the environment for military involvement for most of the 1990s. The future, although unpredictable, appears to offer more of the same. General Shelton, Chairman of the Joint Chiefs of Staff, states, "It is naïve to think that the military will become involved in only those areas affecting our vital national interests."[1] Tomorrow's forces must be flexible, adaptive and responsive to a rapidly changing security environment that will likely demand simultaneous commitment of national assets in many locations performing multiple tasks. Involvement in Operations Other Than War (OOTW) in order to achieve or maintain global stability will likely increase. OOTW include nation assistance, security assistance, humanitarian and disaster relief, peacekeeping and peace enforcement,[2] and are recognized to be a joint services capability.[3] As the military attempts to describe its mission environment, the lexicon of OOTW is expanding, with terms such as Low Intensity Conflict (LIC), Stability and Support Operations (SASO), and Complex Humanitarian Emergencies (CHE). Military medical presence will play a greater role in the mitigation of CHE, which include mass refugee migration, disease in large populations and disaster relief. CHE is a subset of OOTW; the terms are used interchangeably in this paper.

The United States is under pressure to respond to crises using the fewest American assets for effective accomplishment of the task. The reasons for this include: casualty aversion on the part of the public and the National Command Authorities; the need to de-emphasize the perception of American hegemony in the affected part of the world; and husbanding of critically stretched military assets. Although OOTW may be the dominant form of operations in the future, the ability to prosecute a major theater war (MTW) cannot diminish. Future concepts of operation outlined in Joint Vision 2020 call for overwhelming combat power, coupled with a much reduced logistical footprint. Logistical operations to support future operations must capitalize on improved business practices, superb intelligence collection and dissemination capability, underpinned with robust information networking. Simulations and wargaming indicate that in future operations, rapidly transitioning combat forces will have to rely on other than military medical assets to provide casualty care to military members and non-combatants. Putting military medical support in an environment where the support base is under continual threat or where the infrastructure is damaged, destroyed, or not fully developed causes competing demands and exacerbates the need for transportation, logistics and medical assets.[4]

Coordination across joint task force staff functions with non-governmental organizations (NGOs) and other agencies on tomorrow's battlefield will be paramount.

Thorough understanding of the operational environment is essential, not only for MTW, but for the plethora of OOTW that we are likely to engage. The geographical Commanders in Chief (CINCs) rely on the expertise of the J-2 (Intelligence), and the Foreign Area Officers (FAOs) working with the country teams under respective ambassadors to understand the area of operation. Nonmilitary players, including NGOs and international organizations (IOs), other government associated groups, such as the United States Agency for Internal Development (USAID), local contractors, host nation government officials, and the media play increasingly important roles in CHE.

Medical operations are frequently part of OOTW missions, and may even play a lead role. Medical operations have been included in overall Military Civic Action (MCA) programs for several decades. The civil military operations literature documents most lessons learned. Many NGOs, such as the *Médecins sans Frontières* (MSF or Doctors without Borders), Cooperative for Assistance and Relief Everywhere (CARE) and IOs, such as the UN High Commissioner for Refugees and the International Committee of the Red Cross/Red Crescent, will have frequent interaction with military medical organizations in OOTW. Effective medical support in OOTW demands medical unity of effort, a principle of OOTW that has been lacking in many of our more recent military medical operations.[5]

This paper will examine the need for a medical foreign area officer (MFAO) by reviewing medical operations lessons of past OOTW and humanitarian missions. Through examination of future requirements, a plan for the development and utilization of the MFAO will be proposed.

HISTORICAL PERSPECTIVE

Medical operations in OOTW serve a dual role. They provide primary health care for United States troops, and contractors or Allied troops through predetermined agreements. Medical operations also serve a political and diplomatic role, and frequently are the linchpin in our strategy of engagement. There is a long American history of conducting medical operations in foreign lands. Foreign disaster relief increased after WWII and through the 1950s, and was in its heyday during the Kennedy Administration's activist foreign policy. The State Department's Agency for International Development (USAID) also began in 1961.[6]

These early involvements achieved mixed success. The United States had no established policy on relief, nor any agency responsible for its administration. The first legal bases for routine disaster assistance abroad were contained in the 1954 Agricultural and Trade

Development and Assistance Act (PL 480) and in the 1958 Mutual Security Act. Both underscored the economic and political implications of U.S. humanitarian activities in the postwar world.[7] The government's desire to supervise foreign relief resulted in the creation of civilian agencies. The Foreign Operations Administration and the International Cooperation Administration had the task up until 1965, when the Operations Coordinating Board, part of the Executive Office of the President, created a special committee to supervise disaster relief abroad. The Department of State (DOS) assumed responsibility to recommend aid missions for presidential approval. DOS depended on other departments and agencies, including the Department of Defense (DOD), to carry out the presidentially approved missions.

Major military commands acted unilaterally to play a larger role in disaster relief. In the mid-1950s, United States Army Caribbean created disaster survey teams, headed by a quartermaster officer and composed of specialists in medicine, refugee care, food service, communications and other relief functions. These teams were designed to serve as advanced parties in a disaster area to determine how the U.S. could best offer aid.[8] The concept was excellent in theory, but failed in practice.

In 1960, the disaster survey team was first deployed in response to a massive earthquake and tidal wave damage in Chile. As so often occurs today, government officials in Washington reacted to the Chilean request for medical aid before receiving the on-site report from the deployed eleven-man disaster survey team. The United States sent two field hospitals, two air ambulance units, plus laundry and bath, water purification, signal assets and maintenance detachments to support the medical operation. The medical package arrived in country nine days after the natural disaster. Once on the ground, the medical package leaders met with the Chilean officials, the American ambassador and the members of the U.S Army Caribbean disaster survey team that had been in Chile since two days after the earthquake. Reports from the field indicated that Chilean local medical personnel were able to control the situation. The hospital commanders provided medical supplies for the Chileans, but gave direct care or professional advice only if specifically asked by their hosts. Lack of casualties and language barriers halted the continued operation, and the hospital personnel returned to the U.S. within three weeks, donating the hospitals to the Chileans. The air ambulance units provided the most service during the relief operations. Although the operation did not accomplish the originally envisioned mission, the political and diplomatic good will earned over the few weeks was dubbed the "smartest diplomatic move" made in Latin America in years. The failings of the mission received little notice. The relatively massive medical response resulted in too many people deploying and unnecessary costs. The medical professional staff, which was

pulled from fixed facilities in the States, left installations understaffed at home but was underemployed in Chile.[9]

In 1961, flooding in Somalia generated the second major medical disaster response effort. The Prime Minister of Somalia requested medical aid through the American Ambassador, who forwarded the request through the appropriate channels. A medical survey team from Landstuhl, Germany was hastily assembled and arrived in Mogadishu several days later, only to find that neither the embassy, USAID, nor local officials had conducted a valid assessment of need. The medical officer in charge of the survey team requested additional assets from Europe to conduct an air reconnaissance, assess the damage, and provide information for planning the appropriate relief response. After thirty-five days, thirty-eight thousand pounds of food, and over five hundred pounds of medicine were distributed to more than sixty villages.[10]

A smallpox vaccination program in 1961 and earthquake relief in Iran in 1962 provided additional medical operational opportunities. The Iran relief mission overcame environmental challenges, medical supplies mismatched to the needs of the victims, and lack of training among hospital personnel who were drawn together from military hospitals across Europe to staff the 8th Evacuation Hospital. The suspicion and hostility of the local population was overcome only through Iranian cooperation and American flexibility. Religion-based local customs dictated the conduct of daily operations, and were considered strange and peculiar by American personnel.[11]

In 1963, flood relief in Morocco and earthquake response in Yugoslavia taught the Army Medical Department much about providing medical assistance in disaster situations: the importance of the survey team, augmentation of hospital staff with specially trained personnel and equipment, and respect for local sovereignty, customs and culture. The increased frequency of military medical deployments led to the creation of a civilian coordinating agency and a concomitant reduction in Army involvement. The State Department still initiated plans for major disaster missions and could request assistance through the Office of the Secretary of Defense (OSD) and the Joint Chiefs of Staff (JCS), but the American ambassador could unilaterally spend up to twenty-five thousand dollars in disaster relief without approval of superiors at DOS. USAID's Foreign Disaster Relief Division coordinated all overseas relief, regardless of dollar amount. By 1968, the Directorate of Military Support (DOMS) assumed the coordinator liaison duties and monitored all military relief activity abroad. The responsible geographic unified command maintained control over any Army medical units involved, and the

DOMS often sought advice and assistance from the Plans and Operations Division, Office of the Surgeon General.[12]

The growing involvement in Vietnam increased the prominence of civilian control and reduced the direct military involvement in disaster relief, and less frequent and substantial military medical relief occurred during the remainder of the 1960s. However, the new bureaucratic organizational structure did not eliminate the inefficiencies in international medical relief operations. A 1968 earthquake relief mission to Sicily demonstrated gross disconnects between the diplomatic and operational efforts, lack of assessment of need, and non-existent cooperation among the relief forces. The prominence of public relations and increasing television coverage during assistance work became evident. In 1970, a trip report by an epidemiological officer in the wake of a Peruvian earthquake relief mission again recommended DOD surveys and epidemiological studies by trained professionals to validate disaster reports prior to the commitment of DOD resources.[13]

The Special Forces community pioneered new techniques in disaster assistance. Special Action Force Asia (SAFAsia), an Army Special Forces group stationed in Okinawa, developed the Disaster Assistance Relief Team (DART) concept. This twelve-man Special Forces detachment, augmented by medical and engineer personnel, could fly to or be air-dropped at the scene of a disaster anywhere in Asia. The team could conduct immunization programs and carry out other minor medical missions. DART teams proved effective in preventing a Malaysian typhoid epidemic, and during flood relief in the Philippines in the early 1970s. The DART program ended in 1973 when the Special Forces left Okinawa. More traditional methods using an Army survey team followed by a larger medical support package met success during earthquake relief in Nicaragua in late 1972, although the crisis had passed by the time the hospital facilities were deployed and operational.[14]

The Army's major reorganization in 1972-1973 led to great administrative challenges in large-scale disaster response to the Guatemala earthquake of 1976. Again, a mismatch in facilities, staffing and need defined the operation, but alienation of the local populace significantly contributed to the underutilization of services. At the request of the Americans, Guatemalan soldiers blocked the paths to the hospital to keep families from visiting relatives, which local peasants thought absurd. The locals wanted to remove their loved ones from the American hospital because the Americans didn't speak the language, didn't understand the people and never explained anything. The brand of medicine practiced by the Americans did not fit the customs and lives of the population served. Guatemala became choked with American relief workers, resulting in an effort that was overstaffed, over organized and slow.[15]

The Guatemalan experience typified major American relief efforts during the 1970s. Too much aid, from too many sources (including the Army), and too little coordination meant that international aid was as much harmful as helpful. Problems continued even with the creation of the United Nations' Disaster Relief Office, which failed to function as a true coordinating agency.[16]

It is paramount to recognize the political and diplomatic capital involved in medical operations in OOTW and their role in military civic actions. The American medical experience during the Vietnam War illustrates the importance of medical operations in "winning the hearts and minds" of the populace. Medical care became a strategy to increase the civilian population's support for both the Vietnamese government and the presence of American combat forces, and was an important counterinsurgency instrument. The Medical Civic Action Programs (MEDCAP) utilized military medical advisors in MEDCAP I, and military medical providers during MEDCAP II to assist in the war effort.[17]

There were difficulties in planning and executing the MEDCAP missions in the beginning, primarily due to lack of orientation on the environment, language, culture and medical problems facing the American doctors and medical personnel sent to form the MEDCAP I teams. The Government of Vietnam also displayed a lack of responsiveness that resulted in delayed distribution of supplies. The American medical officers were used to a more wealthy and advanced medical system, and had trouble adjusting to the limited pharmacopoeia and primitive state of the supporting South Vietnamese medical system. South Vietnamese doctors were few and badly trained and hospital facilities did not meet the rudimentary standards of plumbing or sanitation. The medical teams, typically composed of six persons (of which one to three were American), operated in conjunction with the Special Forces and Military Assistance Command Vietnam (MACV) medical advisors and provided care to South Vietnamese civilians in displaced persons encampments and in newly declared "strategic hamlets." The MEDCAP personnel trained and qualified additional village health workers and medical aid personnel for the paramilitary forces, and provided direct medical care to the Army of Vietnam military and paramilitary personnel and U.S. advisors.[18] The medical effectiveness of the teams was directly related to the ability to return to a particular hamlet on a repeated basis to provide follow-up care. Funding for the MEDCAP I programs came from the USAID, except for military personnel salaries. The program existed from January 1963 until 1965, providing over three million treatments. MEDCAP I was carefully attuned to the psychological as well as medical impact of the program, and the perception was crafted to provide tangible

evidence that the Government of Vietnam cared about its citizens to create a favorable impression of the South Vietnamese armed forces.[19]

The swell of American military presence in Vietnam in 1965 heralded the MEDCAP II program. The MACV Surgeon had overall responsibility for the technical direction of the program with senior MACV advisors, component commanders and coalition forces responsible for planning and conducting programs within their areas of responsibility. Units of battalion-size or higher and Army hospitals conducted MEDCAP programs.[20] Special Forces conducted MEDCAP operations separate from the MACV Surgeon's programs. The Special Forces efforts placed a greater emphasis on using medical care as a way to improve their intelligence-gathering activities. They provided direct medical care to Civilian Irregular Defense Group units composed of Montagnards, Nuongs, and Cambodians, who were considered outcasts by mainline South Vietnamese society.[21]

As American forces disengaged, the emphasis in MEDCAP programs shifted to training South Vietnamese personnel to assume full responsibility for medical care. This train-the-trainer program used combat soldiers to train village health workers in rudimentary public health practices, and the most basic medical and dental health measures. Medical staff trained South Vietnamese medical personnel in more complicated procedures. By the end of the formal MEDCAP II program in 1972, the disparity between Western medicine and that previously available in South Vietnam had been drastically reduced.[22]

The Vietnam experience revealed that sometimes the military is the best equipped, organized and trained to conduct nation building, a task that the military traditionally shuns. Americans attempted to improve the overall quality of health services throughout South Vietnam through the Provincial Health Assistance Program (PHAP). The PHAP developed from an American government civilian effort under the auspices of USAID in the early1960s. USAID sent surgical teams of American physicians, nurses and technicians to South Vietnamese provincial hospitals. The goals included an immediate increase in the capabilities of the South Vietnamese provincial health system through temporary provision of U.S. personnel and materiel, and a permanent improvement through assistance to the government in planning and organization, personnel and materiel management, and in-service training on medical technical procedures. However, as the civil strife increased, the AID teams were not able to operate as effectively as hoped, and U.S. officials turned to the military for assistance in order to achieve strategic objectives. USAID objected to the military involvement, but the Military Province Health Assistance Program (MILPHAP) began in 1965 with the Army acting as DOD's Executive Agent for the program. The military dominated the sixteen-man teams, although AID officers

also drew teams from other U.S. nonmilitary organizations and recruited contract personnel from non-U.S. sources. Some of the military personnel involved received language training. The Government of South Vietnam also used teams from other nations, which had secondary agreements with USAID.[23]

The convoluted reporting and command relationships among the teams, the military chain of command, and the South Vietnamese demonstrated the opposite of the desired "unity of effort" in OOTW operations. Despite the bureaucratic layers, inefficiencies and difficulties, the program grew and lasted until June 1972, achieving some improvement of quality and quantity of care at provincial hospitals, and district and hamlet dispensaries. The real test of the MILPHAP program would have been its record after the withdrawal of U.S. forces, but the communist take over of South Vietnam precluded such evaluation.[24]

Historically, failures in planning and execution plagued many medical relief missions. There were difficulties in developing good relations between the military unit and host community due to cultural and political differences. Unwieldy bureaucracy marred many operations. In spite of the obstacles, the military medical systems gained valuable experience in planning and deployment, improved their own technical skills and did provide medical relief to needy populations.

The last three decades witnessed the growth of multiple NGOs and UN-associated organizations involved in OOTW. Numerous agencies and directorates claim responsibility for the coordination of medical support operations, but the execution of such operations remain confusing and fragmented. Previous lessons learned appear to be repeating themselves. Relationships between the U.S. military and NGOs during Operation PROVIDE COMFORT (southeast Turkey and northern Iraq in April 1991), Operation SEA ANGEL (Bangladesh in May 1991), Operation RESTORE HOPE (Somalia, December 1992) and Operation RESTORE HOPE (Rwanda, July 1994) demonstrate the importance of an effective cooperative effort between military forces and NGOs in a theater of operations.

A recent interagency report on U.S.-led operations in Kosovo charges that U.S. humanitarian efforts suffered from "fragmentation." NATO "suddenly found itself shouldering a massive humanitarian project" in the number of internally displaced Kosovars, a mission for which it was not prepared.[25] It can be justifiably stated that all humanitarian operations are implicitly political.[26] Medical operations within humanitarian efforts constitute political capital. Military forces and NGOs operate from a position of "altruistic self interest," with a mutually beneficial relationship existing between the military and the NGOs.[27] Our experience over the

past four decades indicates that improved cooperation and coordination facilitates medical operations in OOTW. The question is how best to accomplish that task.

THE FUTURE

The Training and Doctrine Command Army After Next (AAN) study project provides a simulation forum to explore complex issues facing the military in future operations and the Army Transformation Strategy. The Army Medical Department (AMEDD) Center and School conducted wargames in 1998 and 2000 under the AAN initiative; the author was involved in the Joint Medical Wargame 2000 (JMWG). Both wargames provided a forum to examine medical support concepts, capabilities, and notional systems and identified issues and insights key to successful medical support in future military operations. While the 1998 Wargame was distinctly Army in nature, the JMWG 2000 Wargame was more joint and coalition oriented.

During the AMEDD AAN 1998 Wargame, medical care was seen as a potential element of national strategy, and was likened to the "tip of the military spear" as it had been in Operation PROVIDE PROMISE in Yugoslavia.[28] Game players cited the requirement to develop global partnering; to use the medical assets of allies, coalition partners and NGOs in an environment of high casualty surges and reduced in-theater medical and logistical footprint. During this simulation, the concept of the "Global Medic" or Medical Foreign Area Officer (MFAO) was first proposed as a means to facilitate required partnerships. MFAOs were envisioned as in-theater medical affairs subject matter experts who could facilitate support relationships among in-theater players prior to initiation of hostilities and arrival of military forces. The MFAOs would coordinate, plan, and practice support agreements as a routine and continuous effort prior to a time of crisis. The MFAO presence on the CINC's staff would facilitate the advanced medical planning required for allied/coalition/NGO cooperation. Complete interoperability with allied and coalition forces would require continuous peacetime combined training exercises.[29]

The JMWG 2000 was based on the three scenarios used during AAN Spring Wargame 1999, set in the 2015 timeframe. The AAN Spring Wargame 1999 scenario was employed because the outcomes of this free play, force-on-force exercise were already known. The scenario provided an opportunity for retrospective examination of medical planning required to support a joint/combined expeditionary force in a MTW. Additionally, because the AAN Spring Wargame 1999 was well known to the Army community, it served as a vehicle to communicate service and allied partner medical issues and insights. The vignettes forced players to examine medical implications of force deployment and early entry operations, operations in complex

(urban) terrain, and the simultaneous conduct of offensive operations and stabilization and support operations (SASO) in the same theater.[30]

The JMWG 2000 demonstrated that medical support in a theater of operations is a strategic issue for the National Command Authorities (NCA), CINC and Combined/Joint Expeditionary Force (C/JEF) commander.[31] The significance of medical issues in the game impressed both medical and non-medical players. Scenario play spawned many complex questions and issues requiring further in-depth study. Issues such as the size and timing of potential casualty loads, evacuation capability relative to the requirement, medical support to military operations in urban terrain, and transitioning medical support to meet combat and SASO requirements were recognized as having both operational and political components, which could directly impact senior leader decision making processes.[32] Interoperability with allies and medical resources available in the Host Nation or Area of Operations, as well as coordinated medical response with NGOs and IOs, were viewed as critical for future medical operations. Future forces were envisioned to employ the expertise of medical foreign area officers familiar with the strengths, weaknesses, assets and resources available in the theater to provide responsive medical support.[33]

Player comments at the conclusion of the wargame analyzed the various moves and assumptions. In the game, the joint services provided all medical support, but the players assumed instant availability of joint medical assets and relied on the capability of the NGOs already in-theater to care for casualties at the outset of the operation.[34]

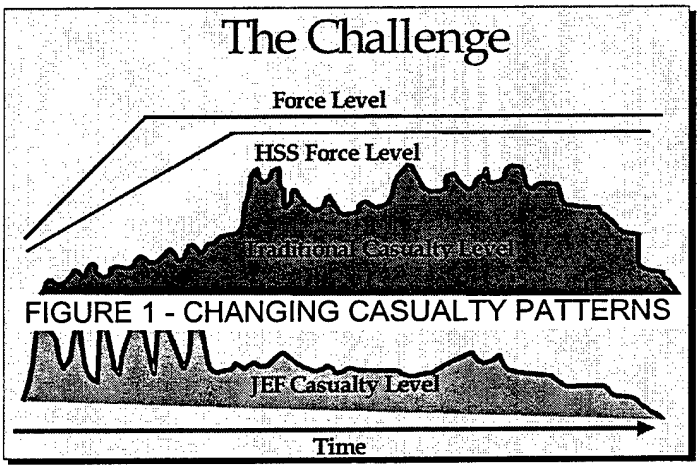

FIGURE 1 - CHANGING CASUALTY PATTERNS

Casualty generation and prediction was an eye-opening lesson learned from the 2000 Wargame. As shown in Figure 1, conducting large-scale insertion operations in a non-permissive environment generated many casualties before robust health services were deployed and operational.

Lack of planning to deal with large numbers of early casualties -- U.S., allied and local national -- created the greatest problem. These casualty spikes required optimal use of in-theater non-military medical capability until the theater health organization was mature enough to handle the mission. This same situation has occurred in numerous humanitarian and disaster relief missions in the past. Often, the military medical support arrived too late to have much

effect on the immediate relief of human suffering.[35] The coordination of host nation, NGO and military medical assets must be accomplished to be most effective in OOTW.

Casualties have an impact on the U.S. domestic, host nation and international political support and the perception of "sustainability." This forces medical operations planners to consider other avenues of medical support, to include NGO and Logistics Civilian Augmentation Programs (LOGCAP) in theater, and constitutes a radical departure from "business as usual" for both military and NGO health care facilities. High coalition casualties will overwhelm the medical system, degrading U.S. domestic support and sustainability. Civilian casualties will overload host nation facilities, decreasing international political support. Large numbers of enemy casualties that become prisoners of war and require care under the Geneva Conventions could also degrade sustainability. During scenario play, participants felt that insertion of medical capability above that organic to maneuver units was "too risky," and it would be too difficult to get into the AOR after D-Day.[36]

During urban operations, players felt that NGO medical capability had to shoulder the responsibility for civilian casualties, because the CINCs would not squander scarce military medical assets on treatment for civilians and refugees during combat operations. The medical plan looked for usable HN infrastructure. Caring for civilian and refugees was a secondary task, but did influence the plans of the Commander of the Joint Expeditionary Force (CJEF). This situation represents a high value, public opinion target for the international community, and increases reliance on interagency cooperation among NGOs/ IOs and the military to care for the suffering.[37] Again, thorough knowledge and pre-arranged agreements and understandings with players in the AOR (NGOs and HN entities) are crucial for success.

Strategic success of the operation will hinge on adequate medical support to the civilian sector in the AOR. This may mean increased military medical support assets, as well as smooth coordination with other medical providers, coalition partners, NGOs/IOs and host nation assets in the AOR. It is likely that NGOs will be overburdened themselves. In the JMWG, the ability of the military to establish refugee camps and provide the needed medical support was assessed as decisive in achieving political support from the U.S. domestic and international community. U.S. support for combat operations will remain high if there are low U.S. casualties. International support will remain high if effective triage and evacuation of coalition troops occur with corresponding medical support to the civilian sector – even if that is simply coordinating or facilitating medical support from other providers with the requisite capability. Politically, if the international community sees that the military and coalition partners are doing everything possible to save lives, the populace affected by the conflict or the disaster will have a favorable

view of the U.S. and coalition effort, which will increase our influence in the region.[38] Optimization and use of all available medical capacity will be critical and may be the only way to meet combat casualty care requirements early in future operations.

Questions of interoperability, standards and quality of care must be resolved prior to the operation in order to take timely advantage of available resources,[39] and is a subject worthy of in-depth study in order to effectively support future operations. The MFAO can provide the requisite expertise to aid the CINC/JTF Surgeon in facilitating the necessary coordination before the crisis. The medical support plan could call for NGOs to care for military forces. This is antithetical to normal operations of the NGO community, but memoranda of understanding between military and NGO medical providers may be an approach to provide medical support to military personnel in exchange for security for NGO operations. The medical FAO and the CINC/JTF surgeon would be instrumental in this task.

Transition to SASO operations post-conflict is a very complex operation. The JMWG emphasized earliest possible use of non-military capabilities so military medical resources could focus on care of casualties from ongoing operations and preparation for future combat.[40] The transition from combat operations to humanitarian support requires thorough planning and coordination, and NGOs/IOs must be linked to the transition strategy. The Civilian Military Operations Center (CMOC) has the most influence in this phase of the operation, and the MFAO provides great leverage in facilitating the medical "battle-handoff" to non-military providers. JMWG players realized the importance of a medical presence in the CMOC. Smooth interagency cooperation and the ability to take advantage of all other assets and agencies in the theater of operations were integral to success in transitioning to SASO. JMWG players' consensus was that medical operations planning was the greatest shortcoming for working with DOS, UN, and NGOs.[41]

WHERE DO WE GO FROM HERE?

The military will continue to be involved in humanitarian and military operations of a lesser scale than all-out combat operations. Future concepts describe military conduct of Advanced Full Dimension Operations (AFDO). The vision of the Chief of Staff of the Army (CSA) clearly delineates the myriad capabilities that tomorrow's forces must have. The CSA's vision describes Full-Spectrum Land Forces capable of victory in MTW, but responsive and flexible to meet other crises; versatile for success in stability and support operations; and durable for extended regional engagement. These land forces must be able to operate as integral members of a joint, multinational, interagency team, and be dominant and lethal at

every point within the spectrum of operations against the asymmetric application of conventional, unconventional and WMD threat capabilities.[42] These capabilities are driving the creation of the Army's Interim Brigade Combat Team and ultimately the Transformation Objective Force. Military medicine can be seen as playing a much larger role in future engagement strategy, however the new administration defines "engagement." Coupling medical activities with other nation assistance efforts, such as engineering projects and education, can better execute the CINC's Theater Engagement Plan (TEP). All nation assistance actions are integrated through the U.S. Ambassador's Mission Performance Plan (MPP), the DOS equivalent of the TEP. Both the MPP and the TEP should reflect the overall national strategy. A more informed and proactive military medical presence can better coordinate the well intentioned, but ill directed on-going medical presence. The synergy of military and diplomatic efforts with those of the NGOs and IOs can be a win-win situation in CHEs.

Some believe that the United Nations should be at the helm for all CHE, especially humanitarian and disaster relief efforts. This is unrealistic, for the United Nations is struggling to get a handle on effectively directing humanitarian assistance efforts. The United Nations Department of Humanitarian Affairs set up a web site that tracks current complex situations, allowing users to stay abreast of emergencies,[43] but there is little organizational substance to take charge. The Armed Forces possess a relative abundance of the resources needed most in disaster situations: transportation, fuel, communications, equipment, medical supplies and expertise. The "can-do" mentality, self-supporting character, rapid response capabilities and hierarchical discipline inherent in the military are essential in the crisis atmosphere of CHEs. Because both NGOs and the public understand that the military has the resources and the know-how, it is reasonable that political authorities consider a military response to international situations to aid resource-poor countries overwhelmed by disaster.[44]

The U.S. military services have unilaterally and jointly made great strides in improving doctrine for OOTW. There is more tactical training at the Joint Readiness Training Center, and several cadets from the United States Military Academy have trained with NGOs overseas for the express purpose of producing future leaders knowledgeable in the NGO-military relationship in peace operations.[45]

Leaders in the AMEDD realize the need to develop new skills for military medical personnel to handle the complexity of medical operations in OOTW.[46] However, no program or plan addresses the formal development of political, military and clinical skills necessary in a medical foreign area specialist. The greatest amalgamation of the requisite military/political/clinical skills and experience operating in the complex CHE environment is

found in the special operations community. Special operations medical personnel undergo extensive cultural, language and clinical training at the JFK Special Warfare Center. Unfortunately, there is little cross-training between the special operations community and the conventional medical force.

There are initiatives underway to improve the knowledge about medical operations in OOTW. U.S. Central Command (USCENTCOM) held its first Central Region Medical Symposium in August 2000. The primary objective of the symposium was to foster military-to-military relationships between key military medical representatives of selected countries in the AOR, and USCENTCOM command and staff personnel. Invitees also included U.S. allies, NGO and U.S. governmental representatives.[47]

The AMEDD Center and School (AMEDDC&S) established a Subject Matter Expert program, available through the Internet.[48] This program was initiated by LTG James Peake, the current Army Surgeon General, while he was the commander of the AMEDDC&S. Medical SMEs provide a repository for cultural and medical expertise to interface primarily with medical foreign visiting delegations, and for medical personnel deploying to a particular theater. The SMEs are not direct assets for a CINC surgeon's staff, nor are they aware of real time resources in the theater AOR. A related program is the Medical Strategic Leadership Program (MSLP). The course brings senior (Lieutenant Colonel level) U.S. and international military leaders together to develop competencies in leadership, multinational contingency planning, disaster relief and humanitarian assistance operations, along with some logistics, legal, civil affairs and resource management training.[49] The MSLP program still falls short of the total spectrum of competencies and regional responsiveness required of the MFAO.

The U.S. Air Force recently developed an International Health Specialist (IHS) Program. Among the stated goals of the IHS program is the development of regionally focused and competent military medical resources, training of Air Force personnel for regional response, and establishment of a career-long regional medical focus. The IHS program is part of the leader development program in the Air Force. The program underscores the Chief of Staff of the Air Force's support to the unified command CINCs by using medics as the lead in global engagement, and optimizes military-military and military-civilian host nation interface, including NGO relationships.[50]

Under the IHS program, International Health Officers will be assigned to unified commands, on the Air Staff, or in other key planning positions, and are expected to play a pivotal role in medical planning operations and deployment execution. The IHS teams will consist of officers and enlisted personnel assigned to an AOR and reporting directly to the

Group or Wing Commander. Teams will focus on regional medical threats, and will facilitate liaison with regional CINCs' surgeons, the J4 Medical Readiness Division, other agencies and the NGOs/IOs operating in the region. Medical personnel will be expected to have competency in their primary specialty, in addition to proficiency in at least one foreign language. The language capability is consistent with the Chief of Staff of the Air Force initiative to have ten-percent of Air Force officers proficient in a second language by 2005. Personnel may apply for a Special Experience Identifier (SEI) based on language proficiency and/or international experience, and will be eligible for future IHS team member positions. Personnel will become knowledgeable in the political, military, economic, medical and cultural aspects of the region associated with their second language. A centralized board selects IHS personnel in January each year. All interested personnel, regardless of Air Force component, are eligible to apply.[51]

Which officer branch specialty best lends itself to MFAO activities is controversial. Nearly all the initial slate of officers selected to begin training in the summer of 2001 for the Air Force IHS program were health care providers. Concerns with the slate include the health care providers' lack of experience with contracting and logistics, and with dealing with DOS and country team officials. However, clinicians provide medical credibility, and a strong background in public health/epidemiology ought to be requisite. Others believe that medical planners offer greater flexibility, in that they already have experience in contracting, NGO coordination, and working with U.S. Embassies.[52] However, medical planners may still require additional training in the cultural, political and language of the AOR served.

The organization of the Surgeon's office in each unified command is not resourced to provide in-depth knowledge of each sub-region in the AOR. Although the framework is in place to "coordinate" medical response to international CHEs within CINC AORs, recent OOTW experiences in Saudi Arabia, Bosnia and Kosovo indicate that the medical community is still relearning the lessons of history for interagency and NGO/IO cooperation.[53] The principle of unity of effort in OOTW continues to be violated.

The need for MFAO capability is evident, and both the Air Force and the Army have made progress in training medical personnel to meet the need. The opportunity is at hand to create a joint medical training program to benefit the unified CINCs and support the national strategy. For physicians, initial training could begin during medical instruction at the Uniformed Services University of Health Science at Bethesda. For non-physicians and those physicians entering service from civilian institutions, short courses in a variety of subjects may be offered at several opportunities, building toward the award of a special skill identifier as an MFAO. Language proficiency may be obtained through civilian training prior to entry on active duty, or

through the Defense Language Institute. Political and cultural training is offered through the JFK Special Warfare Center and School at Fort Bragg, North Carolina.

A single service may find it difficult to carve out additional assets to create an MFAO. Currently, there are no personnel resources within the Army to create the specialty. A solution may be to consider the MFAO a joint medical asset. Although discussion of a proposed joint medical command is outside the scope of this paper, the MFAO is envisioned to be a critical asset in such a structure. Career progression may be assured through centralized management of this specially trained individual, with appropriate instruction to promotion and selection boards. Ideally, officers should be fully trained FAOs by the senior company grade (O-3) or junior field grade (O-4) level in order to be of most use to the service. MFAO training must be considered along with the duration and demands of medical specialty training. Therefore, from an Army perspective, Medical Service Corps and Nurse Corps officers with appropriate public health clinical background initially are best poised to serve as potential MFAOs.[54]

The MFAO should be employed to best benefit the CINC and the CJTF in the overall conduct of the operation. The MFAO should be present in-country to further the medical component of the CINC's Theater Engagement Plan. In addition to identifying and working with NGOs, coordinating the CINC's medical efforts with the Ambassador's Country Team and assessing host nation medical capabilities, the medical FAO can work with host nation medical facilities to bring them closer to Western standards, so they can augment our more austere medical force when the need arises. The MFAO may also assist with medical information gathering, surveillance and reconnaissance,[55] similar to what medical personnel in the special operations community are trained to do. However, the Geneva Conventions prohibit active surveillance activities by medical personnel, and such activity would be detrimental to building trust and cooperation with host nation and allied personnel. Some authors have called for the establishment of a standing regional CMOC;[56] this could be the logical assignment for best use of the MFAO. The need for improved interagency, DOD, DOS, NGO, and IO planning and cooperation has been addressed in Presidential Decision Directive 56.[57] Another proposal adds the MFAO to the country team staff, with coordination with the CINC J-5, J-2 and the CINC Surgeon. Significant reductions in DOS assets and the number of country teams have resulted in a more subregional focus within each CINC AOR, with embassies responsible for more than one country. The MFAO should be considered part of the standing CINC/CJTF Civil Military Operations Center (CMOC) in order to coordinate and facilitate medical care in future military operations.

CONCLUSION

U.S. involvement in military operations other than war to achieve or maintain global stability will continue and likely increase. Future operations will be characterized by fewer military medical assets in theater, especially at times of highest casualty generation. Decades of experience in humanitarian operations indicate that improved coordination of scarce medical resources is required for success. In-depth understanding of the culture, politics and language in an area of operations will be essential to facilitate medical operations in OOTW, and during the termination and transition phases of combat operations.

The current national security strategy of Shape, Respond and Prepare Now demands a more engaged military medical presence. A program should be developed to train joint MFAOs who can effectively facilitate coordination of military, host nation, and NGO/IO medical assets and assist unified CINCs in implementing the national strategy.

WORD COUNT = 6886

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[2]Department of the Army, Operations, Field Manual 100-5 (Washington, D.C.: U.S. Department of the Army, 14 June 1993), 13-0.

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[4]Center for Healthcare Education and Studies, Joint Medical Wargame 2000 Final Report (Fort Sam Houston, TX: U.S. Army Medical Department, 23 August 2000), Appendix II.

[5]Office of the Joint Chiefs of Staff, Joint Doctrine for Military Operations Other Than War, Joint Publication 3-07 (Washington, DC: Office of the Joint Chiefs of Staff, 16 June 1995), III-1.

[6]Gaines M. Foster, The Demands of Humanity: Army Medical Disaster Relief. (Washington, D.C.: U.S. Army Center of Military History, Government Printing Office, 1983),155.

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[8]Ibid., 151.

[9]Ibid.,153-155.

[10]Ibid., 155-157.

[11]Ibid., 158.

[12]Ibid., 164.

[13]Ibid., 165-167.

[14]Ibid., 167-168.

[15]Ibid., 170-172.

[16]Ibid., 172.

[17]John W. De Pauw and George A. Luz, Winning the Peace, The Strategic Implications of Military Civic Action, (New York: Praeger Publishers, 1992), 139-140.

[18]Ibid., 141.

[19]Ibid., 143.

[20]Ibid.

[21]Ibid.,147.

[22]Ibid., 148.

[23]Ibid., 149-150.

[24]Ibid., 151-152.

[25]Steven Mufson, "Report: Infighting, Poor Intelligence Plague U.S. Relief Efforts," The Washington Post. (9 May 2000): A27 [database on-line]; available from UMI ProQuest Direct, Bell & Howell, UMI publication no. 01908286.

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[28]Center for Healthcare Education and Studies, AMEDD After Next Wargame 1998 Final Report, (Fort Sam Houston, TX: U.S. Army Medical Department, August 1999), 29.

[29]Ibid., 39.

[30]Center for Healthcare Education and Studies, Joint Medical Wargame 2000 Final Report (Fort Sam Houston, TX: U.S. Army Medical Department, 23 August 2000), 9.

[31]Ibid., 2.

[32]Ibid., 39.

[33]Ibid., Appendix J2, slide 8.

[34]Ibid., Appendix II.

[35]COL Steven Gouge, MC, interview by author, 29 Dec 2000, Carlisle Barracks, PA. This was the case for the 86th Combat Support Hospital mission for Hurricane Mitch relief in El Salvador, Nov 1998-Feb 1999.

[36]Center for Healthcare Education and Studies, Joint Medical Wargame 2000 Final Report, Appendix II.

[37]Ibid.

[38]Ibid.

[39]Ibid.,19.

[40]Ibid.

[41]Ibid., Appendix II.

[42]Ibid., Appendix A.

[43]Marilynn Larkin, "Hub for Humanitarian Relief Efforts," The Lancet (June 12, 1999): 2079 [database on-line]; available from UMI ProQuest Direct, Bell & Howell, UMI publication no. 01406736.

[44]Thomas G. Weiss, Military-Civilian Interactions: Intervening in Humanitarian Crises (New York: Rowman & Littlefield Publishers, Inc., 1999), 17.

[45]Don Snider, "U.S. Civil-Military Relations and Operations Other Than War,"in Civil-Military Relations and the Not-Quite Wars of the Present and Future, edited by Vincent Davis (Carlisle Barracks, PA: USAWC Strategic Studies Institute, 30 Oct 1996), 6.

[46]Gary L. Sadlon, Army Medical Department Leaders in Military Operations Other Than War, Strategy Research Project (Carlisle Barracks, PA: U.S. Army War College, 27 Mar 2000), 13.

[47]USCINCCENT MacDill AFB, Message, 01 01 292001Z Mar 00; available from <http://www.centcom.mil/organizations/surgeon/Messages/CRMS/Central>; Internet; accessed 25 Jan 01.

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[53]COL Steven Gouge, MC, interview by author, 6 Jan 2001, Carlisle Barracks, PA and COL Terry Carroll, MSC, interview by author, 25 Jan 2001, Carlisle Barracks, PA. Medical experience during Operation JOINT GUARD, Operation JOINT FORGE and Operation PROVIDE COMFORT indicated that medical assessments of the situation were accomplished by the JTF medical commander or representative during advanced party operations. There was little knowledge of in-country medical organizations and resources. Relationships with NGOs were strained or non-existent.

[54]COL Larry E. Campbell, Director of Medical Personnel/Assistant Chief of Staff for Personnel, Office of the Surgeon General/USAMEDCOM, interview by author, 1 March 2001, Carlisle Barracks, PA.

[55]COL L. Harrison Hassell, Director, Center for Health Education and Studies, AMEDDC&S, <Harrison.Hassell@CEN.AMEDD.ARMY.MIL>. "RE: SRP," electronic mail message to Priscilla Hamilton <Priscilla.Hamilton@carlisle.army.mil>, 12 January 2001.

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